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2012

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL537157	A. BUILDING _____ B. WING _____	06/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELVEDERE COMMONS OF FRANKLIN	303 SOUTH ROYAL OAKS BLVD FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 624	1200-08-25-.06 (5)(b)1. Administration (5) Infection Control (b) An ACLF shall have an annual influenza vaccination program which shall include at least: 1. The offer of influenza vaccination to all staff and independent practitioners or accept documented evidence of vaccination from another vaccine source or facility; This Rule is not met as evidenced by: Based on personnel file review and interview, it was determined the facility failed to have documentation of the offer of influenza vaccination for 4 (Employee #1, #2, #4, #5) of 5 sampled personnel files. The findings included: Personnel file review for Employee # 1, #2, #4 and #5 revealed there was no documentation of the offer of influenza vaccine for any of the 4 employees. During an interview at the time of the finding, the Wellness Director verified this finding.	D 624		
D 625	1200-08-25-.06 (5)(b)2. Administration (5) Infection Control (b) An ACLF shall have an annual influenza vaccination program which shall include at least: 2. A signed declination statement on record from all who refuse the influenza vaccination for other than medical contraindications;	D 625		

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D 625	Continued From page 1 This Rule is not met as evidenced by: Based on personnel file review and interview, it was determined the facility failed to have documentation of a signed declination of the influenza vaccination for 4 (Employee #1, #2, #4, #5) of 5 sampled personnel files. The findings included: Personnel file review for Employee #1, #2, #4, and #5 revealed there was no documentation of a signed declination of the influenza vaccination for any of the 4 employees. During an interview at the time of the finding, the Wellness Director verified this finding.	D 625		
D 627	1200-08-25-.06 (5)(b)4. Administration (5) Infection Control (b) An ACLF shall have an annual influenza vaccination program which shall include at least: 4. An annual evaluation of the influenza vaccination program and reasons for non-participation; and This Rule is not met as evidenced by: Based on interview, it was determined the facility failed to perform an annual evaluation of the influenza vaccination program and reasons for non-participation. The findings included:	D 627		

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D 627	Continued From page 2 During an interview on 6/26/12 at 3:00 PM, the Assisted Living Wellness Director stated the facility had not performed an annual evaluation of the influenza program and reasons for non-participation.	D 627		
D 629	1200-08-25-.06 (5)(c)1. Administration (5) Infection Control (c) An ACLF and its employees shall adopt and utilize standard precautions in accordance with guidelines established by the Centers for Disease Control and Prevention (CDC) for preventing transmission of infections, HIV, and communicable diseases, including adherence to a hand hygiene program which shall include: 1. Use of alcohol-based hand rubs or use of non-antimicrobial or antimicrobial soap and water before and after each resident contact if hands are not visibly soiled; This Rule is not met as evidenced by: Based on document review and interview, it was determined the facility failed to follow Centers for Disease Control and Prevention (CDC) guidelines for cleaning glucometers. The findings included: Review of Infection Prevention during Blood Glucose Monitoring and Insulin Administration published by the CDC documented the following..."An underappreciated risk of blood glucose testing is the opportunity for exposure to	D 629		

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D 629	Continued From page 3 bloodborne vivuses (HBV, hepatitis C virus and HIV) through contaminated equipment and supplies if devices used for testing and/or insulin administration (e.g., blood glucose meters, fingerstick devices, insulin pens) are shared. ...Unsafe practices during assisted monitoring of blood glucose and insulin administration that have contributed to transmission of HBV or have put persons at risk for infection include: Using a blood glucose meter for more than one person without cleaning and disinfecting it in between uses." During an interview on 6/26/12 at 9:45 AM, Licensed Practical Nurse (LPN) #1 stated there was 1 glucometer in the Memory Care Unit. She stated currently there are 3 residents that get their glucose checked with the glucometer each morning. When asked by the surveyor how often the glucometer is cleaned, LPN #1 stated one time a day, after the glucometer had been used to check all 3 residents glucose.	D 629		
D 710	1200-08-25-.07 (6)(a) Services Provided (6) An ACLF shall dispose of medications as follows: (a) Upon discharge or death of a resident, unused medications shall be released to the resident, family member, or legal representative unless specifically prohibited by the attending physician or other authorized healthcare provider. This Rule is not met as evidenced by: Based on observation, and interview, it was	D 710		

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D 710	Continued From page 4 determined the facility failed to dispose of discontinued medications in 2 (Pink and Blue Community) of 3 medication storage areas in the Memory Care Unit (MCU). The findings included: 1. Observation on 6/26/12 at 8:30 AM in the Pink Community, revealed in the medication cart there was 1 Glucagon Kit with an expiration date of 2/21/12. During an interview, Licensed Practical Nurse (LPN) #1, present at the time of the above finding in the Pink Community stated the Glucagon Kit belonged to a resident who had been discharged from the facility about 3 months ago. LPN #1 verified the medication was not properly disposed of after the resident was discharged. 2. Observation on 6/26/12 at 8:40 AM in the Blue Community, revealed in the medication refrigerator there was 1 bottle Humulog Insulin 75/25 and 1 injection of Forteo. During an interview, LPN #1, present at the time of the findings in the Blue Community, stated the resident who had received the Humulog insulin no longer resided at the facility. She stated the resident who had received Forteo injections still resided at the facility, but the Forteo had been discontinued about 2 months ago. LPN #1 verified the medication had not been properly disposed of by the facility.	D 710		
D 712	1200-08-25-.07 (6)(c) Services Provided (6) An ACLF shall dispose of medications as follows:	D 712		

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D 712	Continued From page 5 (c) Any non-scheduled drug or device that is misbranded, expired, deteriorated, or not kept under proper conditions or in containers with illegible or missing labels shall be properly disposed of at the ACLF in the presence of another licensed or certified professional. This Rule is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to dispose of expired medications. The findings included: 1. Review of the facility medication policy for expired medications revealed Humulin, Novolin, Lantus and Novolog insulins should be discarded 28 days from the time they are opened. The policy documented Tubersol must be discarded 30 days after it had been opened. 2. Observation on 6/26/11 at 8:45 AM, revealed in the medication refrigerator in the MCU there were 2 opened containers of Tubersol. Neither contained documentation of the date they had been opened. Also in the refrigerator was 1 vial Novolog insulin with an expiration date of 3/12/12 and 1 opened vial Humulin R insulin with documentation it had been opened 6/14/11. During an interview, LPN #1 and the Wellness Director for the MCU, both present at the time of the finding verified the above findings. Both confirmed it could not be determined when the 30 days on the Tubersol would be since the bottles had not been dated when opened.	D 712		

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D 712	Continued From page 6 3. Observation on 6/26/12 at 9:30 AM, revealed in the Assisted Living Unit (AL) there was 1 bottle Novolog insulin dated it had been opened 5/15/12, 1 bottle Humulog insulin dated it had been opened 5/19/12, 1 bottle Novolog insulin dated it had been opened 5/13/12 and 1 opened vial Tubersol that did not document when it had been opened. During an interview on 6/26/12 at 9:30 AM, the Wellness Director of the AL, present at the time of the above findings verified the facility had failed to timely discard of the expired insulins. She confirmed it could not be determined when the 30 days on the Tubersol would be since it was not dated when opened.	D 712		
D 732	1200-08-25-.07 (7)(c)5. Services Provided (7) An ACLF shall provide personal services as follows: (c) Dietary services. 5. An ACLF shall maintain a clean and sanitary kitchen. This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain a clean and sanitary kitchen in the Memory Care Unit (MCU) and the Assistant Living (AL) unit, The findings included:	D 732		

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D 732	Continued From page 7 1. Observation during a tour of the MCU on 6/26/12 at 8:30 AM revealed it was divided into 3 communities. Each community had a kitchen area that contained a refrigerator, sink, stove/microwave, and cabinets. a. Observation of the kitchen in the Pink Community on 6/26/12 at 8:40 AM, revealed the following: In the refrigerator there was 1 large plastic bag grated cheese with no documentation when it had been opened and placed in the refrigerator, 1 open can Ensure with no documentation of a resident name or when it had been placed in the refrigerator, ½ uncovered molded sweet potato, 1 large container liquid with no documentation of what it was opened or when it had been placed in the refrigerator. Both the inside of the refrigerator and freezer contained many liquid and food spills. The kitchen counter top was an uncovered bowl of cookies. In the microwave on a plate was a partially eaten waffle and piece of sausage. In the lower kitchen cabinets were 9 large, open, undated bags of potato chips and cookies. b. Observation of the kitchen in the Blue Community on 6/26/12 at 9:00 AM, revealed in the refrigerator there was 1 large container ranch dressing and 1 large container pimento cheese. Both had been opened, and were not dated when they had been opened. Both the inside of the refrigerator and freezer contained many liquid and food spills. Observation of the cabinets in the kitchen revealed the lower cabinet doors contained many dried food spills. Inside the cabinets, there were 5 large bags of potato chips and cookies that were	D 732		

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D 732	Continued From page 8 not dated when they had been opened. Some of the cabinet doors had missing knobs to open the cabinet and 1 cabinet did not have a door. c. Observation in the Yellow Community on 6/26/12 at 9:15 AM, revealed there was 1 container cottage cheese and 1 large container pimento cheese with no documentation when either had been opened. Both the inside of the refrigerator and freezer contained many liquid and food spills. Observation in the lower kitchen cabinets revealed there were 3 large bags of potato chips and cookies not dated when they had been opened. 2. Observation of the kitchen in AL Unit on 6/26/12 at 9:40 AM revealed in the walk-in refrigerator there was 1 gallon container blue cheese dressing and 1 gallon container cocktail sauce that were not dated when they had been opened. 3. During interviews, the Wellness Director for the MCU, present during the tour of the MCU, verified the above findings in the MCU. The Wellness Director for the AL, present during the tour of the employee refrigerator verified the above findings. The Dietary Manager, present during the tour of the AL kitchen, verified the above findings. She stated all foods and liquids should be labeled with the date they are opened.	D 732		
D 832	1200-08-25-.08 (9)(b) Admissions, Discharges, and Transfers (9) An ACLF utilizing secured units shall provide survey staff with twelve (12) months of the following performance information specific to the	D 832		

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D 832	Continued From page 9 secured unit and its residents at its annual survey: (b) Ongoing and up-to-date documentation that each resident ' s interdisciplinary team has performed a quarterly review as to the appropriateness of placement in the secured unit; This Rule is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to have documentation of each resident's interdisciplinary team quarterly review to show the resident's appropriateness in the secured unit for 2 (Resident #4, #5) of 2 sampled Memory Care Unit (MCU) residents. The findings included: Medical record review for Resident #4 revealed he was admitted to the MCU on 1/6/12. Diagnoses included Dementia. There was no documentation that any quarterly reviews by the interdisciplinary team had been completed. Medical record review for Resident #5 revealed she was admitted to the MCU on 3/17/11. Her diagnoses included Alzheimer's disease. There was documentation of a quarterly review on 10/17/11 and 2/10/12. During an interview at the time of the finding, the Wellness Director verified the facility had failed to document quarterly reviews by the interdisciplinary team.	D 832		
D1036	1200-08-25-.10 (8)(b) Life Safety (8) An ACLF shall ensure that:	D1036		

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D1036	Continued From page 10 (b) The ACLF stores janitorial supplies away from the kitchen, food storage area, dining area or other resident accessible areas; This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to store janitorial supplies away from the kitchen/ food storage area in 3 (Kitchens in Pink, Blue, Yellow Units in Memory Care) of 4 kitchen areas toured. Observation of the 3 kitchens in the Memory Care Unit (MCU) revealed multiple containers of cleaning supplies and aerosol disinfectants were stored in the lower cabinets in the kitchens of the Pink, Blue and Yellow units. During an interview, the MCU Wellness Director stated that is where the cleaning supplies have always been kept.	D1036		
D1038	1200-08-25-.10 (8)(d) Life Safety (8) An ACLF shall ensure that: (d) The ACLF cleans floor and dryer vents as frequently as needed to prevent accumulation of lint, soil and dirt. This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the dryer vents in 2 (Pink and Blue Community) of 3 laundry rooms were clean. The findings included: Observation on 6/26/12 at 10:00 AM, revealed the	D1038		

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D1038	Continued From page 11 dryer vents in the laundry rooms in the Pink and Blue Community of the Memory Care Unit (MCU) revealed the vents had a heavy build up of lint. During an interview, at the time of the findings, the MCU Wellness Director verified the heavy lint build up in the dryer vents.	D1038		
D1040	1200-08-25-.10 (10)(a) Life Safety (10)An ACLF shall maintain its physical environment in a safe, clean and sanitary manner by doing at least the following: (a) Prohibit any condition on the ACLF site conducive to the harboring or breeding of insects, rodents or other vermin; This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the physical environment in a clean and sanitary manner in the Memory Care Unit (MCU). The findings included: 1. Observation in the Pink Community on 6/26/12, revealed in the resident bathrooms in rooms 101,108 and 112 there was mold in the resident's shower. The commode in each above room had a black and red ring at the top of the water line, and the commode was very dirty around the inside top of the commode. 2. Observation in the Blue Community on 6/26/12, revealed in the resident bathrooms in rooms 208 and 209 there was mold in the showers. Each commode had a black and red ring at the top of the commode water line and,	D1040		

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D1040	Continued From page 12 both commodes were very dirty around the inside top of the commodes. 3. Observation in the Yellow Community on 6/26/12 revealed room 305 and 308 had mold in the showers. Each commode had a black and red ring at the top of the water line and. Both commodes were very dirty around the inside top of the commodes. During an interview at the time of the findings, the MCU Wellness verified the facility had failed to maintain a clean and sanitary environment.	D1040		
D1202	1200-08-25-.12 (2)(a) Resident Records (2) Personal record. An ACLF shall ensure that the resident ' s personal record includes at a minimum the following: (a) Name, Social Security Number, veteran status and number, marital status, age, sex, any health insurance provider and number, including Medicare and/or Medicaid number, and photograph of the resident; This Rule is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to ensure the medical record included veteran status and number and marital status for 4 (Resident # 2, #3, #4 #5) of 5 sampled residents. The findings included: Medical record review for Resident #2, #3, #4 and #5 revealed there was no documentation of their	D1202		

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D1202	Continued From page 13 veteran status or marital status. During an interview at the time of the findings, the Assisted Living (AL) Wellness Director stated the facility had not been obtaining this required information.	D1202		
D1204	1200-08-25-.12 (2)(c) Resident Records (2) Personal record. An ACLF shall ensure that the resident ' s personal record includes at a minimum the following: (c) Name and address of the resident ' s preferred physician, hospital, pharmacist and nursing home, and any other instructions from the resident to be followed in case of emergency; This Rule is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to ensure the medical record included the resident's preferred pharmacy and nursing home for 5 (Resident #1-Resident #5) of 5 sampled residents. The findings included: Medical record review for Resident #1, #2, #3, #4 and #5 revealed there was no documentation of any of the resident's preferred pharmacy or nursing home. During an interview at the time of the findings, the Wellness Director stated the facility had not been obtaining this required information.	D1204		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D1223	Continued From page 14	D1223		
D1223	1200-08-25-.12 (5)(a) Resident Records (5) Plan of care. (a) An ACLF shall develop a plan of care for each resident admitted to the ACLF with input and participation from the resident or the resident ' s legal representative, treating physician, or other licensed health care professionals or entity delivering patient services within five (5) days of admission. The plan of care shall be reviewed and/or revised as changes in resident needs occur, but not less than semi-annually by the above-appropriate individuals. This Rule is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to develop a plan of care (POC) within 5 days of admission for 2 (Resident #4 and #5) of 5 sampled residents. The findings included: 1. Medical record review for Resident #4 documented an admission date of 1/6/12. The initial POC was dated 2/10/12. 2. Medical record review for Resident #5 documented an admission date of 3/17/11. There was no POC in the record for the surveyor to review. During an interview at the time of the finding, the Wellness Director verified the POC for Resident #4 had not been done within 5 days of admission. The Wellness Director stated she was unable to locate a POC for Resident #5.	D1223		

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	TNPL537157	A. BUILDING _____ B. WING _____	06/26/2012

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D1608	Continued From page 15	D1608		
D1608	1200-08-25-.16 (3) Disaster Preparedness (3) An ACLF shall participate in the Tennessee Emergency Management Agency local/county emergency plan on an annual basis. Participation includes: (a) filling out and submitting a questionnaire on a form to be provided by the Tennessee Emergency Management Agency; and (b) maintaining documentation of participation that shall be made available to survey staff as proof of participation. This Rule is not met as evidenced by: Based on interview, it was determined the facility failed to participate in the Tennessee Emergency Management Agency (TEMA) emergency plan on an annual basis. The findings included: During an interview on 6/26/12 at 1:45 PM, the Administrator stated the facility did not participate in the TEMA emergency plan.	D1608		

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D 002	1200-08-25 No Deficiencies This Rule is not met as evidenced by: A complaint investigation was conducted on 2/23/12. No deficiencies were cited during this survey.	D 002		

Division of Health Care Facilities

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

C1MV11

If continuation sheet 1 of 1

STATE FORM

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D 624	1200-08-25-.06 (5)(b)1. Administration (5) Infection Control (b) An ACLF shall have an annual influenza vaccination program which shall include at least: 1. The offer of influenza vaccination to all staff and independent practitioners or accept documented evidence of vaccination from another vaccine source or facility; This Rule is not met as evidenced by: Based on personnel file review and interview, it was determined the facility failed to have documentation of the offer of influenza vaccination for 4 (Employee #1, #2, #4, #5) of 5 sampled personnel files. The findings included: Personnel file review for Employee # 1, #2, #4 and #5 revealed there was no documentation of the offer of influenza vaccine for any of the 4 employees. During an interview at the time of the finding, the Wellness Director verified this finding.	D 624	1. Facility will document individually on all employees' status of influenza vaccination offers and signed copy by employee kept in their respective file. This will be done annually each year. This will be monitored annually by Assistant Director and Wellness Director. New and separate documentation will be done annually and signed by employee and placed in employee file. This will be done on all employees. Reason will be stated in file each year why vaccination was declined.	08/08/12
D 625	1200-08-25-.06 (5)(b)2. Administration (5) Infection Control (b) An ACLF shall have an annual influenza vaccination program which shall include at least: 2. A signed declination statement on record from all who refuse the influenza vaccination for other than medical contraindications;	D 625		

Addendum to POC Accepted 7/10/12 pdc (Extension till 8/8/12)

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Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dan William (Bill) Sullivan — TITLE: EXECUTIVE DIRECTOR — (X6) DATE: 7-9-12

STATE FORM 6899 — CBIX11 — If continuation sheet 1 of 16

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D 625	Continued From page 1 This Rule is not met as evidenced by: Based on personnel file review and interview, it was determined the facility failed to have documentation of a signed declination of the influenza vaccination for 4 (Employee #1, #2, #4, #5) of 5 sampled personnel files. The findings included: (2) Personnel file review for Employee #1, #2, #4, and #5 revealed there was no documentation of a signed declination of the influenza vaccination for any of the 4 employees. During an interview at the time of the finding, the Wellness Director verified this finding.	D 625	2. Facility will document individually on all employees' status of influenza vaccination offers and signed copy by employee kept in their respective file. This will be done annually each year. This will be monitored annually by Assistant Director and Wellness Director. New and separate documentation will be done annually and signed by employee and placed in employee file. This will be done on all employees. Reason will be stated in file each year why vaccination was declined.	08/08/12
D 627	1200-08-25-.06 (5)(b)4. Administration (5) Infection Control (b) An ACLF shall have an annual influenza vaccination program which shall include at least: 4. An annual evaluation of the influenza vaccination program and reasons for non-participation; and This Rule is not met as evidenced by: Based on interview, it was determined the facility failed to perform an annual evaluation of the influenza vaccination program and reasons for non-participation. The findings included:	D 627		

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D 627	Continued From page 2 (3) During an interview on 6/26/12 at 3:00 PM, the Assisted Living Wellness Director stated the facility had not performed an annual evaluation of the influenza program and reasons for non-participation.	D 627	3. Facility will document individually on all employees' status of influenza vaccination offers and signed copy by employee kept in their respective file. This will be done annually each year. This will be monitored annually by Assistant Director and Wellness Director. New and separate documentation will be done annually and signed by employee and placed in employee file. This will be done on all employees. Reason will be stated in file each year why vaccination was declined.	08/08/12
D 629	1200-08-25-.06 (5)(c)1. Administration (5) Infection Control (c) An ACLF and its employees shall adopt and utilize standard precautions in accordance with guidelines established by the Centers for Disease Control and Prevention (CDC) for preventing transmission of infections, HIV, and communicable diseases, including adherence to a hand hygiene program which shall include: 1. Use of alcohol-based hand rubs or use of non-antimicrobial or antimicrobial soap and water before and after each resident contact if hands are not visibly soiled; This Rule is not met as evidenced by: Based on document review and interview, it was determined the facility failed to follow Centers for Disease Control and Prevention (CDC) guidelines for cleaning glucometers. The findings included: Review of Infection Prevention during Blood Glucose Monitoring and Insulin Administration published by the CDC documented the following..."An underappreciated risk of blood glucose testing is the opportunity for exposure to	D 629		

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D 629	Continued From page 3 bloodborne vivuses (HBV, hepatitis C virus and HIV) through contaminated equipment and supplies if devices used for testing and/or insulin administration (e.g., blood glucose meters, fingerstick devices, insulin pens) are shared. ...Unsafe practices during assisted monitoring of blood glucose and insulin administration that have contributed to transmission of HBV or have put persons at risk for infection include: Using a blood glucose meter for more than one person without cleaning and disinfecting it in between uses." During an interview on 6/26/12 at 9:45 AM, (4) Licensed Practical Nurse (LPN) #1 stated there was 1 glucometer in the Memory Care Unit. She stated currently there are 3 residents that get their glucose checked with the glucometer each morning. When asked by the surveyor how often the glucometer is cleaned, LPN #1 stated one time a day, after the glucometer had been used to check all 3 residents glucose.	D 629	4. Glucometer will be cleaned after used on each resident. This practice has already begun. The practice of cleaning the glucometer after each resident will be monitored by the Wellness Director and by the Executive Director. The Executive Director will monitor this in Wellness Director meetings and these meetings are held every other week. Documentation of the cleaning will be kept and reviewed in Wellness Director meetings, which are held every other week.	08/08/12
D 710	1200-08-25-.07 (6)(a) Services Provided (6) An ACLF shall dispose of medications as follows: (a) Upon discharge or death of a resident, unused medications shall be released to the resident, family member, or legal representative unless specifically prohibited by the attending physician or other authorized healthcare provider. This Rule is not met as evidenced by: Based on observation, and interview, it was	D 710		

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D 710	Continued From page 4 determined the facility failed to dispose of discontinued medications in 2 (Pink and Blue Community) of 3 medication storage areas in the Memory Care Unit (MCU). The findings included: 1. Observation on 6/26/12 at 8:30 AM in the Pink Community, revealed in the medication cart there was 1 Glucagon Kit with an expiration date of 2/21/12. During an interview, Licensed Practical Nurse (LPN) #1, present at the time of the above finding in the Pink Community stated the Glucagon Kit belonged to a resident who had been discharged from the facility about 3 months ago. LPN #1 verified the medication was not properly disposed of after the resident was discharged. 2. Observation on 6/26/12 at 8:40 AM in the Blue Community, revealed in the medication refrigerator there was 1 bottle Humulog Insulin 75/25 and 1 injection of Forteo. During an interview, LPN #1, present at the time of the findings in the Blue Community, stated the resident who had received the Humulog insulin no longer resided at the facility. She stated the resident who had received Forteo injections still resided at the facility, but the Forteo had been discontinued about 2 months ago. LPN #1 verified the medication had not been properly disposed of by the facility.	D 710	5. Whenever a resident leaves the facility, any unused medication will be released to the resident's family member or legal representative unless physician says no. This practice will be monitored by the nurse supervisors and the Wellness Director. This practice will begin immediately. This will also be reviewed by the Executive Director in Wellness Director meetings, which are held every other week. Documentation of discarding medications will be kept and reviewed in Wellness Director meetings, which are held every other week. 6. Whenever a resident leaves the facility, any unused medication will be released to the resident's family member or legal representative unless physician says no. This practice will be monitored by the nurse supervisors and the Wellness Director. This practice will begin immediately. This will also be reviewed by the Executive Director in Wellness Director meetings, which are held every other week. Documentation of discarding medications will be kept and reviewed in Wellness Director meetings, which are held every other week.	08/08/12 08/08/12
D 712	1200-08-25-.07 (6)(c) Services Provided (6) An ACLF shall dispose of medications as follows:	D 712		

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D 712	Continued From page 5 (c) Any non-scheduled drug or device that is misbranded, expired, deteriorated, or not kept under proper conditions or in containers with illegible or missing labels shall be properly disposed of at the ACLF in the presence of another licensed or certified professional. This Rule is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to dispose of expired medications. The findings included: 1. Review of the facility medication policy for expired medications revealed Humulin, Novolin, Lantus and Novolog insulins should be discarded 28 days from the time they are opened. The policy documented Tubersol must be discarded 30 days after it had been opened. (7) 2. Observation on 6/26/11 at 8:45 AM, revealed in the medication refrigerator in the MCU there were 2 opened containers of Tubersol. Neither contained documentation of the date they had been opened. Also in the refrigerator was 1 vial Novolog insulin with an expiration date of 3/12/12 and 1 opened vial Humulin R insulin with documentation it had been opened 6/14/11. (8) During an interview, LPN #1 and the Wellness Director for the MCU, both present at the time of the finding verified the above findings. Both confirmed it could not be determined when the 30 days on the Tubersol would be since the bottles had not been dated when opened.	D 712	7. Expired medications such as Humulin, Novolin, Lantus and Novolog insulins will be discarded 28 days from the time they are opened. Other medications covered by this policy such as Tubersol must be discarded 30 days after opening. This will begin immediately and be monitored by the nurse supervisor and Wellness Director and reviewed by the Executive Director at the Wellness Director meetings, which are held every other week. Documentation of discarded medications will be kept on file and reviewed at the Wellness Director meetings. 8. Expired medications will be disposed of according to policy. This will begin immediately and will be monitored by the nurse supervisor and Wellness Director and reviewed by the Executive Director at the Wellness Director meetings, which are held every other week. Documentation of discarded medications will be kept on file and reviewed at the Wellness Director meetings.	08/08/12 08/08/12

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D 712	Continued From page 6 3. Observation on 6/26/12 at 9:30 AM, revealed in the Assisted Living Unit (AL) there was 1 bottle Novolog insulin dated it had been opened 5/15/12, 1 bottle Humulog insulin dated it had been opened 5/19/12, 1 bottle Novolog insulin dated it had been opened 5/13/12 and 1 opened vial Tubersol that did not document when it had been opened. (9) During an interview on 6/26/12 at 9:30 AM, the Wellness Director of the AL, present at the time of the above findings verified the facility had failed to timely discard of the expired insulins. She confirmed it could not be determined when the 30 days on the Tubersol would be since it was not dated when opened.	D 712	9. Expired medications will be disposed of according to policy. This will begin immediately and will be monitored by the nurse supervisor and Wellness Director and reviewed by the Executive Director at the Wellness Director meeting. Documentation of discarded medications will be kept on file and reviewed at the Wellness Director meetings, which are held every other week.	08/08/12
D 732	1200-08-25-.07 (7)(c)5. Services Provided (7) An ACLF shall provide personal services as follows: (c) Dietary services. 5. An ACLF shall maintain a clean and sanitary kitchen. This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain a clean and sanitary kitchen in the Memory Care Unit (MCU) and the Assistant Living (AL) unit, The findings included:	D 732		

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D 732	Continued From page 7 1. Observation during a tour of the MCU on 6/26/12 at 8:30 AM revealed it was divided into 3 communities. Each community had a kitchen area that contained a refrigerator, sink, stove/microwave, and cabinets. a. Observation of the kitchen in the Pink Community on 6/26/12 at 8:40 AM, revealed the following: In the refrigerator there was 1 large plastic bag grated cheese with no documentation when it had been opened and placed in the refrigerator, 1 open can Ensure with no documentation of a resident name or when it had been placed in the refrigerator, ½ uncovered molded sweet potato, 1 large container liquid with no documentation of what it was opened or when it had been placed in the refrigerator. Both the inside of the refrigerator and freezer contained many liquid and food spills. The kitchen counter top was an uncovered bowl of cookies. In the microwave on a plate was a partially eaten waffle and piece of sausage. In the lower kitchen cabinets were 9 large, open, undated bags of potato chips and cookies. b. Observation of the kitchen in the Blue Community on 6/26/12 at 9:00 AM, revealed in the refrigerator there was 1 large container ranch dressing and 1 large container pimento cheese. Both had been opened, and were not dated when they had been opened. Both the inside of the refrigerator and freezer contained many liquid and food spills. Observation of the cabinets in the kitchen revealed the lower cabinet doors contained many dried food spills. Inside the cabinets, there were 5 large bags of potato chips and cookies that were	D 732	10. Assignments of staff to keep kitchens clean and sanitary have been made. This has been documented. Also, all foods and liquids will be labeled with the date they are opened. Documentation of these assignments will be monitored by the nurse supervisors, Wellness Director and reviewed by the Executive Director. All of this will begin immediately. This will also be reviewed by the Executive Director in Wellness Director meetings, which are held every other week.	08/08/12

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D 732	Continued From page 8 not dated when they had been opened. Some of the cabinet doors had missing knobs to open the cabinet and 1 cabinet did not have a door. c. Observation in the Yellow Community on 6/26/12 at 9:15 AM, revealed there was 1 container cottage cheese and 1 large container pimento cheese with no documentation when either had been opened. Both the inside of the refrigerator and freezer contained many liquid and food spills. Observation in the lower kitchen cabinets (11) revealed there were 3 large bags of potato chips and cookies not dated when they had been opened. 2. Observation of the kitchen in AL Unit on (12) 6/26/12 at 9:40 AM revealed in the walk-in refrigerator there was 1 gallon container blue cheese dressing and 1 gallon container cocktail sauce that were not dated when they had been opened. (12) 3. During interviews, the Wellness Director for the MCU, present during the tour of the MCU, verified the above findings in the MCU. The Wellness Director for the AL, present during the tour of the employee refrigerator verified the above findings. The Dietary Manager, present during the tour of the AL kitchen, verified the above findings. She stated all foods and liquids should be labeled with the date they are opened.	D 732	11. Assignments of staff to keep kitchens clean and sanitary have been made. This has been documented. Also, all foods and liquids will be labeled with the date they are opened. Documentation of these assignments will be monitored by the nurse supervisors, Wellness Director and reviewed by the Executive Director. All of this will begin immediately. This will also be reviewed by the Executive Director in Wellness Director meetings, which are held every other week. 12. The dietary staff will make sure that all foods and liquids are labeled with the date they are opened in the Assisted Living unit in the walk-in refrigerator. This will be monitored by the Dietary Manager, Assistant Director and the Executive Director. Documentation of inspections by those monitoring will be kept on file.	08/08/12 08/08/12
D 832	1200-08-25-.08 (9)(b) Admissions, Discharges, and Transfers (9) An ACLF utilizing secured units shall provide survey staff with twelve (12) months of the following performance information specific to the	D 832		

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832 Same for 1223
How are you going to go about having the IDT evals to be done? Restate the request
Educate
Mark on tickler
There is no corrective action except just keep this done

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	E	
D 832	Continued From page 9 secured unit and its residents at its annual survey: (b) Ongoing and up-to-date documentation that each resident ' s interdisciplinary team has performed a quarterly review as to the appropriateness of placement in the secured unit; This Rule is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to have documentation of each resident's interdisciplinary team quarterly review to show the resident's appropriateness in the secured unit for 2 (Resident #4, #5) of 2 sampled Memory Care Unit (MCU) residents. The findings included: (13) Medical record review for Resident #4 revealed he was admitted to the MCU on 1/6/12. Diagnoses included Dementia. There was no documentation that any quarterly reviews by the interdisciplinary team had been completed. (14) Medical record review for Resident #5 revealed she was admitted to the MCU on 3/17/11. Her diagnoses included Alzheimer's disease. There was documentation of a quarterly review on 10/17/11 and 2/10/12. During an interview at the time of the finding, the Wellness Director verified the facility had failed to document quarterly reviews by the interdisciplinary team.	D 832		13. Ongoing and up-to-date documentation that each resident's interdisciplinary team has performed a quarterly review as to the appropriateness of placement in the secured unit will be done on each resident. This is the responsibility of the Wellness Director and will be monitored by the Executive Director and Assistant Director. Documentation will be reviewed by the Executive Director and Assistant Director in the Wellness Director meeting every other week. 14. Ongoing and up-to-date documentation that each resident's interdisciplinary team has performed a quarterly review as to the appropriateness of placement in the secured unit will be done on each resident. This is the responsibility of the Wellness Director and will be monitored by the Executive Director and Assistant Director. Documentation will be reviewed by the Executive Director and Assistant Director in the Wellness Director meeting every other week.	08/08/12 08/08/12
D1036	1200-08-25-.10 (8)(b) Life Safety (8) An ACLF shall ensure that:	D1036			

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Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL537157	A. BUILDING _____ B. WING _____	06/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELVEDERE COMMONS OF FRANKLIN	303 SOUTH ROYAL OAKS BLVD FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D1036	Continued From page 10 (b) The ACLF stores janitorial supplies away from the kitchen, food storage area, dining area or other resident accessible areas; This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to store janitorial supplies away from the kitchen/ food storage area in 3 (Kitchens in Pink, Blue, Yellow Units in Memory Care) of 4 kitchen areas toured. Observation of the 3 kitchens in the Memory Care Unit (MCU) revealed multiple containers of cleaning supplies and aerosol disinfectants were stored in the lower cabinets in the kitchens of the Pink, Blue and Yellow units. During an interview, the MCU Wellness Director stated that is where the cleaning supplies have always been kept.	D1036	15. Janitorial supplies will be stored **away** from the kitchen, food storage area, dining area and other resident access areas. The supplies will be moved immediately and this will **not** be allowed again. This will be monitored by the Wellness Director, Assistant Director and Executive Director. This will be reviewed at the Wellness Director meeting held every other week by the Executive Director.	08/08/12
D1038	1200-08-25-.10 (8)(d) Life Safety (8) An ACLF shall ensure that: (d) The ACLF cleans floor and dryer vents as frequently as needed to prevent accumulation of lint, soil and dirt. This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the dryer vents in 2 (Pink and Blue Community) of 3 laundry rooms were clean. The findings included: Observation on 6/26/12 at 10:00 AM, revealed the	D1038		

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D1038	Continued From page 11 dryer vents in the laundry rooms in the Pink and Blue Community of the Memory Care Unit (MCU) revealed the vents had a heavy build up of lint. (16) During an interview, at the time of the findings, the MCU Wellness Director verified the heavy lint build up in the dryer vents.	D1038	16. Dryer vents with the heavy lint build-up will be cleaned and lint removed immediately. This will be done and reviewed by the Maintenance Director. This will be monitored by the Wellness Director, Assistant Director and Executive Director. This will be discussed and reviewed at the Wellness Director meeting held every other week by the Wellness Director, Assistant Director and Executive Director.	08/08/12
D1040	1200-08-25-.10 (10)(a) Life Safety (10)An ACLF shall maintain its physical environment in a safe, clean and sanitary manner by doing at least the following: (a) Prohibit any condition on the ACLF site conducive to the harboring or breeding of insects, rodents or other vermin; This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the physical environment in a clean and sanitary manner in the Memory Care Unit (MCU). The findings included: (17) 1. Observation in the Pink Community on 6/26/12, revealed in the resident bathrooms in rooms 101,108 and 112 there was mold in the resident's shower. The commode in each above room had a black and red ring at the top of the water line, and the commode was very dirty around the inside top of the commode. 2. Observation in the Blue Community on (17) 6/26/12, revealed in the resident bathrooms in rooms 208 and 209 there was mold in the showers. Each commode had a black and red ring at the top of the commode water line and,	D1040	17. Every resident's bathroom in the Memory Care unit will immediately be examined to insure safe, clean and sanitary conditions exist. This will be the responsibility of the Executive Director, Wellness Director and Assistant Director. This will be a continual process going forward. Daily rounds will be made and documentation kept of the rounds by the Executive Director, Assistant Director and Wellness Director.	08/08/12

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D1040	Continued From page 12 both commodes were very dirty around the inside top of the commodes. 3. Observation in the Yellow Community on (17) 6/26/12 revealed room 305 and 308 had mold in the showers. Each commode had a black and red ring at the top of the water line and. Both commodes were very dirty around the inside top of the commodes. During an interview at the time of the findings, the MCU Wellness verified the facility had failed to maintain a clean and sanitary environment.	D1040	17. Every resident's bathroom in the Memory Care unit will immediately be examined to insure safe, clean and sanitary conditions exist. This will be the responsibility of the Executive Director, Wellness Director and Assistant Director. This will be a continual process going forward. Daily rounds will be made and documentation kept of the rounds by the Executive Director, Assistant Director and Wellness Director.	08/08/12
D1202	1200-08-25-.12 (2)(a) Resident Records (2) Personal record. An ACLF shall ensure that the resident ' s personal record includes at a minimum the following: (a) Name, Social Security Number, veteran status and number, marital status, age, sex, any health insurance provider and number, including Medicare and/or Medicaid number, and photograph of the resident; This Rule is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to ensure the medical record included veteran status and number and marital status for 4 (Resident # 2, #3, #4 #5) of 5 sampled residents. The findings included: Medical record review for Resident #2, #3, #4 and #5 revealed there was no documentation of their	D1202	18. Documentation of obtaining the Veteran status and marital status will begin immediately. Obtaining this information will be the responsibility of the Community Outreach Director, Wellness Director, Assistant Director and Executive Director. This documentation will be reviewed at the Wellness Director meeting held every other week.	08/08/12